HEALTH CARE FINANCING ADMINISTRATION

(dollars in millions)

	2000	2001	2002	Request
	Actual	Enacted	Request	+/-Enacted
Budget Authority Outlays	\$322,459	\$354,485	\$386,527	+\$32,042
	\$316,007	\$354,520	\$386,751	+\$32,231
FTE	4,446	4,610	4,632	÷22

SUMMARY

The FY 2002 budget request for the Health Care Financing Administration (HCFA) is \$386.8 billion in net outlays. The request finances Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), the Health Care Fraud and Abuse Control Program (HCFAC), State insurance enforcement, and HCFA's operating costs. This budget reflects an increase of \$32.2 billion over FY 2001.

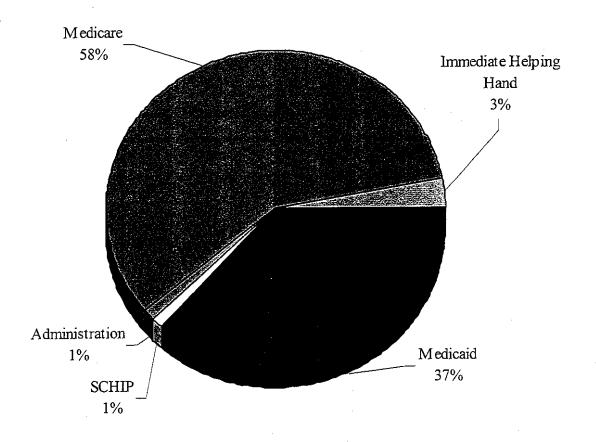
The President's FY 2002 budget includes important proposals for modernizing the Medicare program, a program which represents our Nation's commitment to our seniors and the disabled. Major initiatives include: funding the Immediate Helping Hand program; modernizing HCFA's infrastructure to better serve beneficiaries over the long-term, including taking steps to decrease the regulatory burden; investing in HCFA's accounting systems to strengthen operations and realize long-term efficiencies; and continuing our fight against Medicare waste, fraud, and abuse. We will continue to make important improvements to the Medicare coverage process by making it more open, understandable, and predictable for beneficiaries, providers, Congress and the public.

The President's FY 2002 budget includes nearly \$156 billion – nearly \$3 billion this year and \$153 billion over ten years (FY 2002-2011) – to reform Medicare and provide immediate prescription drug coverage to low-income seniors and those with high out-of-pocket drug costs.

The President's Budget also protects the integrity of the Medicaid program. Last year, Congress took an important step to protect the integrity of the Medicaid program by passing legislation to address the "upper payment limit" (UPL) loophole, which allowed States to draw down billions of dollars in Federal matching payments for hospitals and nursing homes without any assurance that these payments were used for their intended purposes. But this legislation only partially addressed the problem, because it created a higher upper payment limit for non-State government operated hospitals. The President's Budget closes the loophole by prohibiting new hospital loophole plans from receiving the higher upper payment limit proposed in the Department's final rule implementing the upper payment limit legislation.

HCFA FY 2002 NET OUTLAYS

Total = \$386.8 *billion*:



MEDICARE

CURRENT MEDICARE ACTIVITY

Overview: Medicare is the Federal health insurance program for people age 65 or older and people under age 65 who are disabled or suffer from end-stage renal disease (ESRD). In FY 2002, the program will serve approximately 40 million eligible individuals. Medicare consists of three parts:

- Part A Hospital Insurance (HI) is an entitlement for all qualified beneficiaries. Part A pays for inpatient hospital care, some skilled nursing facility care, home health care related to a hospital stay, and hospice care. The HI program is funded through the HI Trust Fund, which receives most of its income from the HI payroll tax (2.9 percent of payroll, split evenly between employers and employees). The Medicare Trustees recently reported that the HI Trust Fund's depletion date has improved slightly, from 2025 to 2029, but HI spending will begin to exceed tax receipts by 2016.
- Part B Supplementary Medical Insurance (SMI) coverage is optional. However, 94 percent of those enrolled in Part A enroll in Part B. Part B pays for medically necessary physician services. outpatient hospital services, treatment for ESRD, laboratory services, durable medical equipment, home health care, and certain other medical services and supplies. The SMI program is funded through the SMI Trust Fund. Enrollees pay 25 percent of Part B costs (or \$50 per month in 2001), with remaining costs covered by general revenue. The

- SMI Trust Fund does not face insolvency like the HI Trust Fund since the law allows SMI to tap into the general fund to ensure its solvency.
- Part C The Medicare+Choice
 Program, which is available to most
 beneficiaries, offers the option of
 receiving Medicare benefits through
 private organizations such as
 managed care plans.

Recently, there has been much discussion about the relationship of the budget to Medicare's Trust Funds. Some would like to set aside the "surpluses" accruing to the HI Trust Fund from the rest of the budget and permanently require budget surpluses equal to these Trust Fund "surpluses."

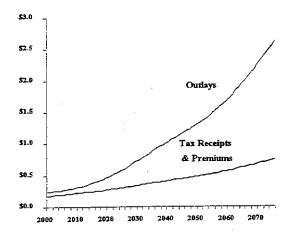
In a sense this argument is moot, in that the President's proposed Additional Needs and Contingency Reserve far exceeds the "surpluses" in the HI Trust Fund over the period 2002-2011. Nonetheless, viewing Medicare HI activities in isolation is flawed.

The President's Budget spends every penny of Medicare tax and premium collections over the next ten years on Medicare. When you isolate all Medicare revenues and expenditures, there is no Medicare Part A surplus. In fact, a comprehensive analysis of the Medicare program, which takes into account the Supplemental Medical Insurance Trust Fund (Part B), as well as the HI Trust Fund (Part A), reveals there is a deficit. The Medicare program today will require a \$1.2 trillion transfer from the general fund to meet expenditures over the period 2002-2011. These annual transfers from the general fund are nothing more than the government making paper transactions with itself. They

have no economic consequences and should not be considered when you look at Medicare from the perspective of the Federal Budget. Moreover, a significant part of the HI surplus is due to an accounting gimmick that shifted a portion of the home health expenditures from HI to SMI to extend the solvency date of the HI Trust Fund. The shift had no economic consequence, nor did it change total Medicare spending, but it did have the effect of making the HI Trust Fund appear more "solvent."

Therefore, when Medicare is examined in this more comprehensive manner, over the period 2002-2011, the projected HI surplus is overwhelmed by the SMI deficit. As such, Medicare as a whole is running a deficit, not a surplus. This deficit is projected to be \$645 billion over the next ten years, or \$52 billion in FY 2002.

MEDICARE OUTLAYS VS. TAX RECEIPTS AND PREMIUMS (Dollars in Trillions)



NOTE: Outlays include Part A and Part B in constant 2000 dollars.

Comprehensive Measure of Medicare's Solvency: Currently, there is no comprehensive measure of Medicare's solvency that accounts for SMI finances, as well as HI. This underestimates the magnitude of Medicare's financial problem.

The Medicare Trustees acknowledge this disconnect in their 2001 Trustees report by stating that, "Although this report focuses on the financial status of the HI Trust Fund, it is important to recognize the financial challenges facing the Medicare program as a whole and the need for integrated solutions." To this end, the Administration will work to establish a comprehensive measure of Medicare's solvency in order to assess the overall financial picture of the program.

Medicare+Choice: Medicare offers beneficiaries a variety of coverage options. Beneficiaries may choose to remain in the traditional fee-for-service program or enroll in a Medicare+Choice plan, which could be a traditional HMO, a preferred provider organization, or a private fee-for-service plan.

Currently, about 5.8 million, or about 15.6 percent of beneficiaries, are enrolled in a Medicare+Choice plan. These figures are lower compared to last year, when 6.3 million beneficiaries, or about 17 percent of all beneficiaries, were enrolled. This drop in enrollment reflects the large number of plans, about 316, that have left the Medicare+Choice program or reduced their service areas in the last three years.

Medicare+Choice plans have left the program for a variety of reasons, including increased costs, slower Medicare payment increases and difficulty in maintaining provider networks. To address these concerns, BIPA increased payments to Medicare+Choice plans by about \$11 billion over five years. While Medicare+Choice organizations generally used the money to enhance provider payments, some plans reduced premiums and enhanced prescription drug coverage.

Medicare Spending Growth: Under current law, Medicare gross benefit outlays are projected to increase from \$252 billion in FY 2002 to \$447 billion in FY 2011. The program is expected to grow at 6.6 percent per year during this period. Part A benefit

outlays are projected to grow from \$142 billion in FY 2002 to \$241 billion in FY 2011, at an average annual growth rate of 6.1 percent. Part B benefit outlays are expected to grow from \$110 billion in FY 2002 to \$207 billion in FY 2011. The Part B average annual growth rate during the projection period is 7.3 percent.

Health Care Fraud and Abuse Control Program (HCFAC): Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established the HCFAC Program. The program combats health care fraud, waste, and abuse. Included within this overarching program is the Medicare Integrity Program (MIP), which is run by HCFA, and the Fraud and Abuse Control Program.

MIP consists of financial audits of provider cost reports, medical and utilization reviews of individual claims, and the identification of Medicare beneficiaries who have other insurance plans with primary responsibility for paying claims. Funds are also earmarked to support detection and investigation of program fraud and abuse. HCFA also funds provider education and training activities associated with preventing fraud, waste and abuse and audits of managed care plans.

In FY 2002, HIPAA authorizes \$700 million for MIP, a \$20 million increase over FY 2001. Within this level, HCFA will fund activities that will stop unnecessary payments before they leave the Trust Funds through pre-payment review and provider education. These actions help lower the payment error rate cited in recent Chief Financial Officer's reports.

Also under MIP, HCFA is developing contractor-specific error rates that will gauge the progress the agency is making in correcting payment errors by providers. This effort began in Summer 2000 and HCFA hopes to begin getting usable information in FY 2002.

HIPAA also created the Fraud and Abuse Control Program. This program

funds much of the health care investigational and prosecutorial activities of the HHS Office of Inspector General and the Department of Justice. The Fraud and Abuse Control Program increased \$27 million in FY 2002 over FY 2001, to \$209 million. In FY 2001, HCFA received \$2.5 million from this account to work with States that wish to develop Medicaid payment error rates.

The Administration's health care fraud, waste, and abuse control efforts have paid off handsomely. In FY 1999, the last year for which we have data, \$9.9 billion was identified in savings from MIP activities, representing an 18:1 return on our investment. In addition, we have also cut the Medicare overpayment error rate in half from FY 1996 through FY 2000, from 14 percent to 6.8 percent. Recent Medicare Trustee's reports have cited our health care fraud, waste, and abuse control efforts as a contributing factor in the slower Medicare spending growth experienced over the last three years.

Peer Review Organizations: Peer Review Organizations (PROs) were established by Title XI of the Social Security Act, Part B, to serve the following functions:

- Improve the quality of care for beneficiaries by ensuring that professionally recognized standards of care are met;
- Enhance program integrity by ensuring that Medicare only pays for items that are reasonable and medically necessary; and,
- Protect beneficiaries by addressing individual beneficiary's complaints, and hospital issued notices of noncoverage and Emergency Medical Treatment and Labor Act (EMTALA) "dumping" violations.

In FY 2002, PROs will begin a new round of work; HCFA is developing the new requirements for this work. Current PRO

contracts include performance standards that will provide benchmarks for: national and local health improvement projects; a program to prevent payment errors; a project to improve quality of care for Medicare+Choice beneficiaries; and a project to reduce the disparity between care received by minorities and all other beneficiaries.

PROPOSED LAW

The President's FY 2002 budget includes nearly \$156 billion – nearly \$3 billion this year and \$153 billion over ten years (FY 2002-11) – to reform Medicare and provide immediate prescription drug coverage to low-income seniors and those with high out-of-pocket drug costs.

Immediate Helping Hand (IHH): The President's FY 2002 budget allocates nearly \$46 billion – approximately \$3 billion in FY 2001 and approximately \$43 billion over four years (FY 2002-2005) – for States to provide prescription drug coverage for low-income beneficiaries and those with catastrophic drug costs. The IHH proposal is funded from general revenue and surpluses, not Medicare Trust Fund dollars.

- The IHH proposal complements and builds on plans that are currently available in almost half the States.
- Individuals with incomes up to \$11,600 and married couples with incomes up to \$15,700 who are not eligible for Medicaid or a comprehensive private retiree benefit would pay no premium and no more than a nominal charge for prescriptions.
- Individuals with incomes up to \$15,000 and married couples with incomes of up to \$20,300 would receive subsidies for at least half the cost of the premium for high-quality drug coverage.

- Individuals of any income level with out-of-pocket drug costs exceeding \$6,000 per year would receive catastrophic coverage.
- IHH is fully funded by the Federal government and provides States with the flexibility to choose how to establish coverage or enhance existing plans. States choosing to participate in the program would receive an allocation based on the State's share of Medicare beneficiaries with incomes below 175 percent of poverty.
- This proposal would not create a new entitlement program; rather, IHH would sunset in December 2004 or as soon as a comprehensive Medicare prescription drug benefit is implemented.

Medicare Reform: Comprehensive Medicare reform is an urgent priority. We need to increase the quality of care provided to seniors and the disabled, to streamline burdensome and inflexible bureaucratic controls, and to improve the program's financing. The Medicare program has not kept pace with modern medicine. Today, Medicare covers just over half of the average senior's annual medical expenses and the benefits package is lacking. Moreover, Medicare faces a looming fiscal crisis. A full assessment of the health of both the Part A and Part B Trust Funds reveals that spending exceeds the total of tax receipts and premiums dedicated to Medicare and that gap is expected to widen dramatically. Even without a financing problem, Medicare modernization would be necessary to ensure beneficiaries get high quality health care. The President's budget devotes \$110 billion beginning in FY 2005 to urgently needed modernizations.

The President is committed to modernizing Medicare. Under the

President's principles for reform, Medicare should:

- Provide better coverage options, streamline regulations, and provide higher quality care;
- Ensure that all seniors have affordable access to prescription drug coverage as part of a modernized Medicare program;
- Provide better options for protection against high out-of-pocket expenses, particularly for low-income seniors; and,
- Ensure greater overall financial security, including an accurate measure of the financial status of the program as a whole, without raising payroll tax rates.

MEDICARE TRUST FUND OVERVIEW

		ions)

	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>+/-</u>
Aged Disabled Total Beneficiaries	34.2	34.3	34.6	+0.3
	<u>5.3</u>	5.6	<u>5.7</u>	+0.1
	39.5	39.9	40.3	+0.4

MEDICARE OUTLAYS

(dollars in millions)

	2000 <u>Actual</u>	2001 Enacted	2002 <u>Request</u>	Request +/-Enacted
Current Law:	·			
HI Benefits	\$125,992	\$135,092	\$141,843	+\$6,751
SMI Benefits	<u>88,875</u>	<u>102.698</u>	<u>110,124</u>	<u>+7,426</u>
Subtotal, Medicare Benefits	\$214,867	\$237,790	\$251,967	+\$14,177
Administration /1	2,912	3.267	3,552	+285
HCFAC /2	715	820	860	+40
Peer Review Organizations	279	505	424	-81
Transfers to Medicaid	<u>O</u>	<u>170</u>	<u>70</u>	<u>-100</u>
Total Outlays, Current Law	.\$218,773	\$242,552	\$256,873	+\$14,321
Premiums		<u>-23,433</u>	<u>-27,034</u>	<u>-3,601</u>
Total Net Outlays, Current Law		\$219,119	\$229,839	+\$10,720
Proposed Legislation:				
Medicare Benefits	\$0	\$0	\$0	\$0
Proposed User Fees	0	0	-115	-115
Premium Interaction	<u>0</u>	<u>0</u>	<u>20</u>	<u>+20</u>
Total Medicare Proposed Legislation	\$0	\$0	-\$95	-\$95
Total Net Outlays, Proposed Law	. \$196,866	\$219,119	\$229,744	+\$10,625

^{1/} Includes Administrative payments to the SSA and other non-HCFA agencies.

^{2/} Health Care Fraud and Abuse Control, includes FBI, excludes OIG.

MEDICAID

SUMMARY

Medicaid is a jointly-funded,
Federal-State program that provides medical
assistance to certain low-income groups. In
FY 2002, it will cover approximately
34.3 million individuals including children,
the aged, blind, and/or disabled and people
who meet eligibility criteria under the old
Aid to Families with Dependent Children
(AFDC) program. Under current law, the
Federal share of Medicaid outlays is
expected to be about \$143 billion in
FY 2002. This is a \$14 billion (11 percent)
increase over projected FY 2001 spending.

MEDICAID SAVINGS PROPOSAL

Medicaid Upper Payment Limit (UPL)
Reform: The FY 2002 budget would save
\$606 million in FY 2002 by taking further
steps to restrict the Medicaid "upper
payment limit" loophole. This proposal
would prohibit new hospital UPL plans
approved after December 31, 2000 from
receiving the higher upper payment limit
proposed in the final rule. The final rule had
allowed local government-operated hospitals
to receive up to 150 percent of what
Medicare would pay for the same services.
This is known as the upper payment limit.

OTHER PROPOSALS

Health Care Tax Credits: The Administration will encourage the purchase of private health insurance through health care tax credits.

Increased State Flexibility: The Administration will explore a range of options for reforming Medicaid and the State Children's Health Insurance Program (SCHIP) to improve the way these programs provide health care to the poor and near-

poor. After consulting with the States, the Administration will develop ideas to increase State flexibility and ensure that Medicaid and SCHIP are being effectively used to promote health insurance coverage. The review of these programs will emphasize giving States the flexibility to use private insurance, when possible, and to coordinate with employment-based insurance for those who have access to it. Within the framework of increased State flexibility, the Administration will also work with States to maintain and reinforce the fiscal integrity of the Medicaid and SCHIP programs by controlling Medicaid costs and ensuring the fiscally prudent management of these programs.

BACKGROUND

Under Medicaid, State expenditures for medical assistance are matched by the Federal government using a formula based on per capita income in each State relative to the national average. Federal matching rates for FY 2002 are projected to range from 50 to 76 percent for medical assistance payments. The Federal matching rate on average is approximately 57 percent.

Historically, eligibility for Medicaid has been based on qualifying under the cash assistance programs of AFDC or Supplemental Security Income (SSI). With passage of the Temporary Assistance for Needy Families (TANF) program in 1996, which replaced AFDC, eligibility for Medicaid and cash assistance were de-linked. However, Medicaid eligibility remains tied to AFDC program rules in place as of July 16, 1996. All those who qualify under the 1996 AFDC rules and most SSI recipients, commonly referred to as the "categorically eligible," are covered under State Medicaid programs. States have

the option to cover some individuals not eligible under AFDC or SSI rules (e.g., people with higher incomes in institutions, low-income pregnant women and children, and aged, blind, and disabled people below the poverty line), and may cover people at higher incomes by disregarding a portion of their incomes. States may also cover "medically needy" individuals. Such individuals meet the categorical eligibility criteria, but have too much income or too many resources to meet the financial criteria.

Medicaid covers pregnant women and infants whose family income does not exceed 185 percent of the Federal poverty level. Medicaid coverage of children ages 6 through 18, born after September 30, 1983, whose family income does not exceed 100 percent of the Federal poverty level, is being phased in. By 2002, all children under the age of 19 living below the poverty level will be eligible for Medicaid.

In addition, Medicaid pays Medicare premiums, deductibles, and copays for certain low-income seniors and disabled individuals.

Generally, States are required to provide a core of 13 mandatory services to eligible categorically needy recipients, including: inpatient and outpatient hospital care; health screening, diagnosis, and treatment to children; family planning; physician services; and, nursing facility services to individuals over 21. States may also elect to cover any of over 30 specified optional services, which include prescription drugs, clinic services, dental, eyeglasses, and services provided in intermediate care facilities for those with mental retardation.

Medicaid outlays grew 9.1 percent from FY 1999 to FY 2000. Prescription drug spending, nursing home and community-based long term care costs have been significant contributors to this expenditure growth, and are expected to continue to contribute to program growth in future years. State programs providing "enhanced payments" to institutional providers have

also played a significant role in driving up Medicaid costs at an accelerated rate. Although recently issued regulations will eventually curtail much of the impact of these payments, the transition periods and increase in hospital payment limits included in the new rules will contribute to higher spending growth for a number of years.

WAIVER ACTIVITY

States have considerable flexibility in structuring the Medicaid program, including determining provider payment rates and certification standards, and developing alternative health care delivery programs. In addition, waivers of various portions of Federal law are also available to States.

Numerous States have restructured eligibility and coverage under Medicaid through the use of demonstration waivers granted under section 1115 of the Social Security Act. A number of States are using section 1115 demonstration waivers to reform health care by expanding coverage without increasing the amount the Federal government would spend otherwise.

CHANGES IN MEDICAID DUE TO THE BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)

The Benefits and Improvement and Protection Act of 2000:

 Increased funds for safety net hospitals by setting FY 2001 Statespecific disproportionate share hospital (DSH) allotments at FY 2000 levels adjusted for inflation and setting FY 2002 allotments at FY 2001 levels adjusted for inflation. It also allows States to provide public hospitals DSH payments up to 175 percent of net uncompensated care costs for two years. In addition to these DSH provisions, BIPA provided special funding for certain

- public hospitals that meet selected criteria.
- Directed the Secretary of HHS to finalize the regulation addressing a reimbursement loophole that threatens the fiscal integrity of the Medicaid program. The regulation was published January 12, 2001 and took effect March 13, 2001. (Refer to the Medicaid Savings Proposal section of this chapter.)
- Established a new payment system for health centers starting in FY 2001 that is based on centers' FY 1999 and 2000 reasonable costs.
- Extended, through FY 2002, existing
 Medicaid eligibility for those leaving
 welfare for work, allowing these
 beneficiaries to maintain Medicaid
 coverage for 12 months. BIPA also
 simplifies enrollment for low-income
 Medicare beneficiaries that qualify
 for Medicaid and permits States to
 use more sites, such as schools and
 homeless shelters, to enroll children
 in Medicaid or SCHIP.

MEDICAID OVERVIEW

(average enrollees in millions)						
	<u>2000</u>	<u>2001</u>	<u>2002</u>			
Aged 65 and Over	3.9	3.9	4.0			
Blind and Disabled	6.7	6.8	6.9			
Needy Adults	6.3	6.4	6.4			
Needy Children	<u>16.5</u>	<u>16.8</u>	<u>17.0</u>			
Total	33.4	33,9	34.3			

MEDICAID OUTLAYS

(outlays in millions)

	2000	2001	2002	Request
	<u>Actual</u>	<u>Enacted</u>	<u>Request</u>	+/- Enacted
Current Law: Benefits /1 State Administration	\$111,832	\$121,855	\$135,034	+\$13,179
	6.089	6,998	<u>7.995</u>	+997
Total Net Outlays, Current Law	\$117,921	\$128,853	\$143,029	+\$14,176

^{/1} Includes Vaccines for Children Outlays.

MEDICAID PROPOSALS: COSTS AND SAVINGS

(dollars in millions)

	FY 2002	FY 02-06	FY 02-11
Savings Proposals:			
Medicaid Upper Payment Limit	-\$606	-\$6,877	-\$17,376
Cost Proposal:			
VA Nursing Home Extension (Medicaid effect)	<u>\$0</u>	<u>\$0</u>	<u>+\$1,200</u>
Total Outlays, Proposed Law	-\$606	-\$6,877	-\$16,176

STATE GRANTS AND DEMONSTRATIONS

THE TICKET TO WORK AND WORK INCENTIVES IMPROVEMENT ACT (TWWIIA)

The Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA) expanded State options under Medicaid for workers with disabilities.

In addition to the two optional Medicaid categories created by TWWIIA, the legislation also created new grants to fund both a demonstration program and a grant program.

The demonstration program (\$250 million from FY 2001-2006) allows States to receive Federal financial participation to develop a program to provide Medicaid-equivalent coverage to workers with health conditions which, without medical treatment, will cause them to become disabled and qualify for Supplemental Security Income or Social

Security Disability Insurance. The demonstration will determine whether providing health coverage prevents deterioration in their health condition.

The Medicaid Infrastructure Grant Program (section 203 of TWWIIA) makes \$150 million available over five years (from FY 2001-2005) to States to design, establish and operate programs that provide items and services to people with disabilities who work. These funds may also be used to conduct outreach campaigns to educate beneficiaries about the availability of such programs. The minimum award to States is \$500,000 per fiscal year.

In February 2001, as part of the New Freedom Initiative, the President indicated that he would direct Federal agencies, including HHS, to continue to swiftly implement TWWIIA.

STATE GRANTS AND DEMONSTRATIONS

(outlays in millions)

	2000	2001	2002	Request
	<u>Actual</u>	<u>Enacted</u>	Request	+/- Enacted
Budget Authority	\$0	\$62	\$67	+\$5
	\$0	\$16	\$29	+\$13

STATE CHILDREN'S HEALTH INSURANCE PROGRAM

BACKGROUND

The Balanced Budget Act of 1997 (BBA) created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act.

SCHIP is a partnership between Federal and State governments that helps provide children with the health coverage they need. SCHIP reaches children whose families have incomes too high to qualify for Medicaid but too low to afford private health insurance.

Title XXI appropriated almost \$40 billion to the program over ten years (FY 1998 through FY 2007). States with an approved SCHIP plan are eligible to receive an enhanced Federal matching rate, which ranges from 65 to 85 percent, drawn from a capped allotment.

States have a high degree of flexibility in designing their programs. They can implement SCHIP by: 1) expanding Medicaid, 2) creating a new, non-Medicaid Title XXI separate State program, or 3) a combination of both approaches. Generally, uninsured children up to 18 years old in families at or below 200 percent of the Federal poverty level (who are not eligible for Medicaid) are eligible for SCHIP.

There were several changes to the SCHIP program in the Balanced Budget Refinement Act of 1999 (BBRA). BBRA changed the SCHIP allotment formula to stabilize States' annual SCHIP allotments effective for FY 2000 allotments and beyond. BBRA also provided additional budget authority of \$249 million for U.S. Territories. BBRA improved data collection and evaluation activities by providing \$10 million to the Department of Commerce to increase the sample size of the Current Population Survey (CPS) and \$10 million for a SCHIP evaluation of 10 States.

audit, and the GAO to report to Congress, every three years on State compliance with the requirement that SCHIP applicants must be first screened for Medicaid, and if eligible, are enrolled in Medicaid. BBRA directed the Secretary to establish a data clearinghouse on Federal health programs and children's health.

IMPLEMENTATION & ENROLLMENT STATUS

As of September 1999, SCHIP plans were approved for all 50 States, the District of Columbia, and five Territories. As of March 2001, States have received approval for 21 Medicaid expansion programs, 16 separate programs, and 19 combination programs, with eight amendments under review. In FY 2000, 3.3 million children were enrolled in SCHIP – a 70 percent increase over the number of children enrolled in FY 1999.

The scope of coverage under SCHIP continues to increase. Many States have adopted additional expansions of coverage. At the end of FY 2000, 24 States covered children in families with incomes up to 200 percent of the Federal poverty level. Eleven States went beyond that and covered children above 200 percent of poverty with six States covering children with incomes up to 300 percent of poverty. New Jersey covers children in SCHIP up to 350 percent of poverty.

SCHIP WAIVER STATUS

Section 1115 waivers allow States to waive certain provisions of Federal law to demonstrate innovative methods for improving children's coverage and the quality of services for children. In January 2001, the first waivers granted in the

SCHIP program were awarded to New Jersey, Rhode Island and Wisconsin. Through a waiver, these States will offer health insurance coverage to parents of children eligible under either SCHIP or Medicaid. In addition, New Jersey's and Rhode Island's demonstration projects will expand coverage to pregnant women. Currently, there are several States seeking waivers.

CHANGES DUE TO THE BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (BIPA)

BIPA introduced the following changes to the SCHIP program:

Special Rule for Redistribution and Availability of Unspent FY 1998 and FY 1999 SCHIP Allotments: BBA required that States that did not use annual SCHIP allotments within three years must return all unused funds to the Federal government for redistribution to States that have already exhausted their allotments. BIPA established a new reallocation formula for FY 1998 and FY 1999 allotments whereby States would be entitled to either receive redistributed funds or retain a proportion of the unused funds, which remain available through FY 2002. Each Territory that expends its allotment receives 1.05 percent of the total amount available for redistribution. States that retain funds may use up to 10 percent of the funds for outreach activities.

Created Presumptive Eligibility in SCHIP: BIPA gave authority to States to make a child presumptively eligible for SCHIP. If the child is later found ineligible for the program, States can claim those costs as a benefit cost instead of within the 10 percent spending cap used for administrative costs.

THE SCHIP FINAL RULE

The SCHIP Final Regulation was published in the Federal Register on January 11, 2001. The final rule provides States with additional flexibility in certain areas such as:

- Premium assistance programs, also referred to as employer-sponsored insurance;
- Substitution prevention; and,
- Self-identification of American Indians and Alaska Natives.

The final rule also contains patient protections such as access to health care specialists and access to emergency services when and where the need arises. The rule underscores the statute on policy areas such as ensuring that children are enrolled in the program for which they are eligible and ensuring that cost-sharing is nominal.

The SCHIP final rule has been placed on hold for 60 days until June 11, 2001 per the President's Executive Memorandum to withhold implementation of pending, but not yet implemented, regulations.

SCHIP OVERVIEW

(dollars in millions)

	2000	2001	2002	Request
	Actual	Enacted	Request	+/-Enacted
Total Outlays, Current Law /1	\$1,220	\$4,032	\$3,355	-\$6 77

Note: There is no proposed law in SCHIP for FY 2002.

^{/1} The total outlays include program spending in separate SCHIP, combination, and Medicaid expansion programs.

PROGRAM MANAGEMENT

PROGRAM MANAGEMENT REQUEST

Overview: HCFA's FY 2002 Program Management budget request is \$2.35 billion in budget authority, a \$109 million or 4.9 percent increase over the FY 2001 appropriation. The total program level request is \$2.4 billion. This level assumes \$17 million in user fee collections from Medicare+Choice plans for the National Medicare Education Program (NMEP), as well as user fees for the Clinical Laboratory Improvement Amendments program and for the sale of data.

This budget also includes two proposed user fees totaling \$115 million. Because this amount is already reflected in HCFA's FY 2002 current law request of \$2.35 billion, the enactment of these user fees would offset the appropriation by the amount of the proposals. To facilitate this process, we will submit "trigger" language authorizing the collection and spending of the fees and a proposed legislation schedule. If the Appropriations Committees adopt the "trigger" language for one or more user fee proposals, and the fees are enacted, HCFA's appropriation would be reduced by an amount equivalent to the estimated collections.

The Program Management account provides staff and resources for administering Medicare, Medicaid, the State Children's Insurance Program (SCHIP), and various Health Insurance Portability and Accountability Act of 1996 (HIPAA) activities. With these funds, HCFA: coordinates and oversees the work of contractors who process 970 million claims; answers beneficiary and provider inquiries; surveys health care facilities to ensure quality of care is provided to Medicare beneficiaries; conducts research to improve

payment, service delivery, and quality for all HCFA programs; and informs beneficiaries regarding their health care options in the Medicare program.

HCFA's responsibilities have grown with each new major health care law or budget reconciliation. HIPAA, the Balanced Budget Act of 1997 (BBA), the BBRA of 1999, and the Benefits Improvement and Protection Act of 2000 (BIPA) gave HCFA new responsibilities.

In addition, HCFA, like all Federal agencies, must comply with government reform legislation, such as: the Chief Financial Officer (CFO) Act of 1990, the Government Management Reform Act of 1994, the Federal Financial Management Improvement Act (FFMIA) of 1996, the Information Technology Management Reform Act of 1996, the Debt Collection Improvement Act of 1996, and the Government Performance and Results Act of 1993. These six laws alone have had a significant impact on HCFA's operations and have required substantial new investment without providing a commensurate increase in administrative resources.

Medicare Contractors: The Medicare contractors' budget supports a broad array of operational activities. The budget is \$1.52 billion, an increase of \$165 million over the FY 2001 appropriation, including NMEP funding.

By law, the Medicare program is administered by private insurance companies, or contractors. Contractor responsibilities include: processing claims and making benefit payments; responding to the needs and inquiries of Medicare beneficiaries and health care providers and suppliers; and developing and implementing

management changes to improve program operations. In addition, Medicare contractors funds a variety of mission critical information technology systems. For example, it funds managed care systems, standard processing systems, and maintenance on current contractor systems.

HCFA is making a transition in this budget from three major categories (Claims Processing, Productivity Investments, and Beneficiary and Provider Services) to more descriptive categories:

- Ongoing Activities: carriers' and fiscal intermediaries' regular activities, such as processing claims, holding hearings and appeals, answering inquiries, and educating providers and beneficiaries.
- Systems Maintenance: activities to keep shared claims processing systems current.
- Operations: Common Working File (CWF) operations, funding for termination costs of contractors leaving the program, and moving all contractors to three standard processing systems.
- Enterprise-Wide: the HCFA Data
 Center (contractor-operated), the
 Medicare data communications
 network, and hardware and software
 maintenance.
- Legislative Mandates: funding for implementing new legislation such as HIPAA, BBA, BBRA, BIPA, CFO, and FFMIA.
- Program Improvements: replacement of the Medicare managed care processing system and the CWF system, contractor oversight, and reducing regulatory burden on health care providers.

To allow time to adjust to these new categories, this section will refer to the traditional Claims Processing, Productivity

Investments, and Beneficiary and Provider Services categories in describing this year's budget request.

In FY 2002, HCFA will process 970 million claims and answer 40 million inquiries. There has been a slight increase in the unit cost to process a claim in recent years. In FY 2002, the unit cost to process a Part A and Part B claim will be \$0.88 and \$0.67, respectively, slightly higher than current FY 2001 unit cost projections of \$0.87 for a Part A claim and \$0.66 for a Part B claim.

Approximately 65 percent of the FY 2002 Medicare contractors program level request will be spent on processing claims (\$988 million in FY 2002, a 21.5 percent increase over the FY 2001 level). The Medicare contractors expects to see 44 million more claims than FY 2001, partially due to a large number of beneficiaries who left Medicare+Choice (M+C) and returned to the fee-for-service program.

Beneficiary and provider services comprise 23 percent of the Medicare contractors budget. At \$356 million in FY 2002, this portion of our request is 21 percent higher than our FY 2001 submission. This amount will pay for telephone, written, and walk-in communications with beneficiaries and providers, including toll-free lines for both beneficiaries and providers. These activities rise with the enactment of every new piece of legislation dealing with Medicare.

A portion of the funding for the NMEP can also be found in this line. The annual Medicare handbook, as well as other beneficiary and provider publications and services, are funded under this activity. This money also supports the hearings and reconsiderations stages of the claims process. Medicare fiscal intermediaries and carriers handle the initial portion of the appeals process following an adverse ruling on a claim. We will spend \$107 million in FY 2002 to carry out this important

function, an 11 percent increase over FY 2001.

The final portion of Medicare contractors funding is productivity investments. Productivity investments enhance the efficiency and cost effectiveness of Medicare's claims process. In FY 2002, HCFA will fund: Medicare contractor Oversight, including the HCFA Integrated General Ledger Accounting System (HIGLAS); consolidation of contractor claims processing to three standard systems; and contractor non-renewal costs incurred when a Medicare contractor leaves the Medicare program.

Federal Administration: For FY 2002, the President's budget requests \$531.7 million for HCFA's Federal administrative costs. This is an increase of \$27 million over the FY 2001 operating plan. The FY 2002 appropriation request supports a staffing level of 4,632 FTE, a slight increase from the current FTE levels of 4,610 FTE. The additional funding of \$27 million will allow HCFA to cover pay increases, fully fund its 4,632 FTE level, and begin work on the Financial Accounting and Control System (FACs), an internal system integral to HCFA's financial management efforts. It also supports the extensive data processing requirements for the Medicare and Medicaid programs, as well as necessary maintenance of HCFA's many automated data systems.

Research, Demonstrations and Evaluation: The FY 2002 budget requests \$55.3 million for the Research, Demonstrations and Evaluation program, \$83 million less than the FY 2001 enacted level. This reduction includes the elimination of \$87 million in FY 2001 earmarked projects and other program items not requested in last year's President's Budget plus \$4 million in money dedicated to BIPA research projects.

HCFA's research program supports research and demonstration projects to

develop and implement new health care financing policies and to evaluate the impact of HCFA's programs on beneficiaries, providers, States, other customers and partners. Information from HCFA's research program is used by Congress, the Executive Branch, and States to improve the efficiency, quality, and effectiveness of the Medicare, Medicaid, and SCHIP programs.

Basic research funds will also be used to conduct evaluations of Medicare+Choice, SCHIP, Medicaid State Reform, and NMEP.

In addition to basic research, this budget funds the Medicare Current Beneficiary Survey, which continues to be a critical source of data on health care usage and health status of Medicare beneficiaries. Finally, the research budget includes \$19.2 million for Congressional research required by BBA, BBRA, and BIPA...

Survey and Certification: Ensuring the safety and quality of care provided by health facilities is one of HCFA's most critical responsibilities. HCFA contracts with State agencies to inspect health facilities providing services to Medicare and Medicaid beneficiaries and ensure compliance with Federal health, safety, and program standards.

HCFA's FY 2002 budget proposes \$242.1 million to fund survey and certification activities, the same level of funding as FY 2001. Included in this total is \$27.8 million to continue implementing activities associated with the Nursing Home Oversight Improvement Program, such as: imposing immediate sanctions on nursing homes found guilty of a second offense that causes actual harm to residents; conducting more frequent inspections of nursing homes with repeat violations; and conducting more focused reviews of a nursing home's efforts to prevent bed sores, dehydration, and malnutrition. HCFA will also continue to invest money to expedite investigation of resident complaints within a ten-day time frame.

Another \$190.6 million will allow us to inspect long-term care facilities, home health agencies, and accredited hospitals at the legislatively mandated frequencies. For the remaining facility types, HCFA will maintain the FY 2001 recertification levels. HCFA expects to complete a total of almost 25,000 initial or annual inspections. In addition, we estimate conducting more than 40,000 visits in response to beneficiary or family complaints.

The remaining \$23.8 million will fund base support contract activities, most notably: operation of the Quality Improvement and Evaluation System (QIES), which contains quality outcome data that surveyors can use to better target on-site inspections of poor performing providers; maintenance and enhancements to the Online Survey Certification and Reporting (OSCAR) data system, which contains information on nursing home survey results and outcomes; support services for surveying psychiatric hospitals; and accuracy reviews of the information submitted on the Minimum Data Set for nursing homes and the Outcome and Assessment Information System (OASIS) for home health care.

National Medicare Education

Program: In the FY 2002 budget, HCFA will continue to fund activities that will help beneficiaries understand and assess their options under the Medicare program, including Medicare+Choice.

The NMEP will fund activities to inform Medicare beneficiaries of their options, including original Medicare, health maintenance organization (HMO), preferred provider organization (PPO) and private fee-for-service plans. NMEP will also provide complete and comprehensible information about these options to facilitate their decision-making process. The President's budget provides approximately \$80.5 million to finance NMEP activities. NMEP is funded through a variety of sources, including \$52 million from

Program Management, as well as an estimated \$11.5 million in the Peer Review Organization (PRO) account, and \$17 million in Medicare+Choice user fees.

In FY 2002, the NMEP will fund the following activities: mailings to beneficiaries with general information about Medicare, plus specific information on plans available in their area; a toll-free telephone service staffed by customer service representatives able to provide information on available plans; www.medicare.gov, the user-friendly Internet site that provides comparative information on plans by zip code; as well as other programs involving State and local entities.

Clinical Laboratory Improvement
Amendments: The Clinical Laboratory
Improvement Amendments of 1988
(CLIA '88) expanded survey and
certification of clinical laboratories from
Medicare-participating and interstate
commerce laboratories to all facilities testing
human specimens for health purposes.
CLIA '88 also introduced user fees for
clinical laboratories to finance survey and
certification activities. User fees are
credited to the Program Management
account but are available until expended for
CLIA activities.

The CLIA program is fully operational, with about 169,600 laboratories registered with HCFA; about 27 percent of the laboratories are subject to routine inspection (every 2 years) under the program. Workloads for each inspection period include a 5 percent sample review of the 17,000 accredited laboratories, surveys of 23,100 non-accredited laboratories, State validation surveys of 850 accredited laboratories, and approximately 1,700 follow-up survey and complaint investigations.

PROGRAM MANAGEMENT PRIORITIES

HIGLAS: HCFA currently has no uniform financial management system to account for the tens of billions of dollars spent on Medicare benefits each year. Contractors use ad hoc, PC-based spreadsheets and a series of fragmented and overlapping systems to maintain their accounts receivable. Further, most do not use more rigorous double entry accounting methods or claims processing systems with general ledger capabilities. The current approach to financial management makes it difficult to verify the accuracy of reported activities, which increases the risk of administrative and operational errors and misstatements.

The General Accounting Office (GAO) and the Office of Inspector General (OIG) have echoed the concerns regarding HCFA's financial accounting systems in recent annual reports to the Congress. In sum, the current system is inadequate to: detect and collect money owed to the Medicare Trust Funds; retain a clean opinion on financial statements without more expensive, alternative efforts; and comply with financial management statutory requirements. The HCFA Integrated General Ledger Accounting System (HIGLAS) will ensure that HCFA can meet all of these objectives by creating a state-ofthe-art uniform Medicare accounting system.

HIGLAS represents a coordinated approach to improving the accounting and financial management processes used by HCFA's Medicare contractors to administer the Medicare Parts A and B programs, and the agency's central administrative accounting and financial management processes. The goals of HIGLAS are to deploy an integrated, enterprise-wide financial management solution to support administrative and program financial management needs. The project will focus on the contractors' accounts receivable, accounts payable, general ledger, and

reporting processes and replace HCFA's legacy accounting system and systems that currently support its procurement, travel management, grants management, and asset management. In FY 2002, HCFA plans to spend \$53 million for both IGLAS and FACS. HIGLAS is an important component of HCFA's Medicare contractor Oversight.

Capital Improvements: A number of HCFA's information technology systems are antiquated and require upgrading or outright replacement. HCFA is now in the midst of redesigning and replacing its Medicare managed care system. A system that was built to accommodate a small beneficiary population enrolling in a small number of risk health maintenance organizations is being replaced by a system to accommodate a larger number of beneficiaries enrolling and disenrolling in a great variety of managed care plans.

HCFA has surveyed the systems and databases that support the claims processing function and has developed a plan to upgrade or replace a number of mission critical systems to take advantage of the new computing and communications power available now and in the near future. The Secretary is fully supportive of these efforts and has made this as a major priority for the Department, dedicating \$36 million in HCFA's Medicare contractors for capital improvement.

The Nursing Home Oversight
Improvement Program: The President's
Budget commits \$67.3 million in mandatory
and discretionary funds to the Nursing Home
Oversight Improvement Program (NHOIP)
in FY 2002, which enables HCFA to
continue ensuring quality care for our
Nation's nursing home residents. The
NHOIP has enabled HCFA to make
numerous improvements in our nation's
nursing homes. In conjunction with States,
HCFA now: imposes immediate sanctions
against nursing homes that have caused
harm to a resident in consecutive survey

cycles, focuses on preventing bed sores, malnutrition, and abuse as part of the annual nursing home survey; investigates complaints alleging actual harm to residents within ten days; and staggers surveys and conducts visits on weekends, early mornings and evenings, when quality, safety and staffing problems may be more likely to occur. HCFA also conducts more frequent inspections of nursing homes with repeated serious violations. A preliminary report published last summer and updated in December 2000 found significant progress in several areas targeted by the NHOIP:

- almost 12 percent of nursing home surveys were begun during off-hours as compared to 1 percent in 1998;
- the percentage of special focus facilities with findings of immediate jeopardy to resident health or safety has dropped from 27 percent to 2 percent;
- State surveyors are identifying more facilities that fail to prevent or care for bed sores and are also citing more nursing homes for abuse; and,
- the number of imposed per-instance civil money penalties increased
 15 fold between FY 1999 and FY 2000.

Management Reform: The Medicare program, with ever increasing pages of regulations, administrative guidelines, and other endless directives issued on a monthly basis, leaves providers and beneficiaries often bewildered and frustrated. The current system is too complex, too centralized, and becoming more so each year. Burdensome regulations and other central directives force providers to take time away from patients to comply with excessive and complex paperwork.

The GAO concluded as recently as January 2001 in its *High-Risk Update* that HCFA "lacks sufficient information on newly designed payment systems to

determine whether providers are being paid appropriately for the services they deliver."

Reforming HCFA will include employing every strategy appropriate to enhance quality health care options for beneficiaries rather than relying on increasingly punitive regulations, arbitrary and multiple pricing systems, and delays to maintain the status quo.

One of the top priorities of this
Administration is improving management.
The Administration intends to consider
fundamental changes to HCFA's mission
and structure in order to successfully
administer the Medicare, Medicaid, and
State Children's Health Insurance programs.
HCFA will undertake a major effort to
modernize and streamline its operations to
effectively manage these programs.

Implementing Legislation: HCFA has made substantial progress towards implementing legislation. In particular, HCFA has:

- Successfully implemented 249 of the 359 separate Balanced Budget Act (BBA) provisions, or 70 percent of the BBA provisions.
- Fully implemented 85 of the 126, or 67 percent, of the Balanced Budget Refinement Act (BBRA) changes.
- Implemented the Ticket to Work and Work Incentives Improvement Act.
- Completed work on the health insurance reform and fraud and abuse prevention sections of the Health Insurance Portability and Accountability Act (HIPAA).

LEGISLATION SUPPORTING THE DISCRETIONARY BUDGET

The FY 2002 President's Budget includes two user fee proposals that, if enacted, could improve the efficiency and lower the cost of processing Medicare claims in the future. In addition, the

Secretary is requesting that Medicare's contracting process be modernized by eliminating costly provisions that stifle competition and drive up administrative costs.

Paper Claim User Fee: Allows the Secretary to assess a \$1.50 fee on any claim not submitted electronically. Paper claims are expensive to process compared to electronic claims. Converting a large percentage of the remaining three percent of Part A claims and 18 percent of Part B claims that are submitted as paper will help lower processing costs. This fee could be waived at the discretion of the Secretary for providers whose special circumstances make it very difficult for them to comply with the submission requirements (\$65 million).

Duplicate Claim User Fee: Allows the Secretary to assess a \$1.50 fee for each duplicate or unprocessable claim submitted by providers. Duplicate or unprocessable claims are a drain on a system that must process 970 million claims over the course of a year (\$50 million).

Medicare Contracting Reform: One of the Secretary's major commitments in improving Medicare is the reform of an antiquated and inefficient contracting system incorporated in law since the program's beginning. Among the issues that the Secretary wishes to address are:

- Allowing carriers to include entities that are not health insurance organizations;
- Providing Secretarial flexibility in contracting for and in assigning fiscal intermediaries;
- Eliminating special provisions for terminating contracts;
- Repealing fiscal intermediary requirements that are not costeffective; and,
- Providing more Secretarial flexibility with respect to renewing contracts and the transfer of functions.

PROGRAM MANAGEMENT OVERVIEW

(dollars in millions)

	2000 <u>Actual</u>	2001 Enacted	2002 Request	Request +/-Enacted
Medicare Contractors	\$1,239	\$1,357	\$1,522	+\$165
Survey and Certification	210	242	242	0
Federal Administration	486	505	532	+2 7
Research	<u>61</u>	<u>138</u>	<u>55</u>	<u>-83</u>
HCFA Budget Authority Subtotal	\$1,996	\$2,242	\$2,351	+\$109
CLIA/HMO and Data Spending	\$ 45	\$45	\$ 45	\$0
National Medicare Education Program	<u>95</u>	<u>17</u>	<u>17</u>	<u>o</u>
Reimbursable Spending Subtotal	\$140	\$62	\$62	\$0
CLIA/Sale of Data/HMO User Fees	-4 5	-4 5	-4 5	0
National Medicare Education Program	<u>-95</u>	<u>-17</u>	<u>-17</u>	<u>0</u>
Us er Fee Subtotal	-\$140	-\$62	-\$62	\$ 0
Proposed Discretionary User Fees	\$0	\$0	-\$115	-\$115
Proposed Budget Authority	\$1,996	\$2,242	\$2,236	-\$6
Proposed Outlays	\$1,996	\$2,242	\$2,236	-\$6
FTE	4,446	4,610	4,632	+22

HCFA SUMMARY

(dollars in millions)

	2000 <u>Actual</u>	2001 Enacted	2002 Request	Request <u>+/-Enacted</u>
Current Law:				
Medicare Trust Fund	\$218,773	\$242,552	\$256,873	+\$14,321
Medicaid	117,921	128,853	143,029	+14,176
SCHIP	1,220	4,032	3,355	-677
State Grants and Demonstrations	<u>0</u>	<u>16</u>	<u>29</u>	<u>+13</u>
Total Outlays, Current Law	\$337,914	\$375,453	\$403,286	+\$27,833
Premiums	<u>-21.907</u>	<u>-23,433</u>	<u>-27,034</u>	<u>-3,601</u>
Total Net Outlays, Current Law	\$316,007	\$352,020	\$376,252	+\$24,232
Proposed Law:				
Medicare	. \$0	\$0	\$0	\$0
Medicaid	0	0	-606	-606
SCHIP	0	0	0	0
State Grants and Demonstrations	0	. 0	0	0
Immediate Helping Hand /2	0	2,500	11,200	+8,700
Premium Interaction	0	0	20	+20
User Fees	<u>0</u>	0	<u>-115</u>	<u>-115</u>
Total	\$0	\$2,500	\$10,499	+\$7,999
Total Net Outlays, Proposed Law/1	\$316,007	\$354,520	\$386,751	+\$32,231

^{/1} Total net outlays equal current law outlays minus the impact of proposed legislation and offsetting receipts.

^{/2} The Immediate Helping Hand figure for FY 2001 reflects proposed law and has not been enacted.